Draft
Recommendations to Improve
The Children's Mental Health System of Care
Children's Mental Health Workgroup

Resource Documents:
Report of the Governor's Mental Health System Task Force (June, 2002)
CASSP State Plan 2002 –2004
Recommendations of the Foster Child Mental Health Collaborative
CASSP Position Paper: Children's Mental Health Services in Arkansas

Introduction

The children of Arkansas are not adequately served by the current mental health system. It has been recommended that action should be taken by all parties with responsibility for the well-being of the children of Arkansas to insure that comprehensive mental health services are available on a statewide basis to adequately meet established and ongoing needs. If our children do not have access to appropriate community-based mental health services, the cost to society is tremendous, not just in terms of dollars but also in the quality of life for children and their families. For the most part, those children and their families do not have the means or political influence to be heard in regard to the service system that they depend on to function on a daily basis.

The demand for services to meet the critical needs of emotionally disturbed youth in our communities continues to grow while the services available are not increasing and in fact are shrinking in many parts of the state.

According to the DHS report to the Children and Youth Subcommittee, the annual expenditure of Arkansas public funds to pay for children's mental health services in 2001 including Medicaid reimbursements was approximately $127 million. In spite of this expenditure serious problems remain.

Why is this? It is partly because so much of what we spend on mental health services in Arkansas is spent on very expensive inpatient psychiatric care for a relatively small number of people. Almost everyone involved in the public mental health system—professionals, providers, consumers and would-be consumers, their families, and their advocates—agrees that many of these patients could be well-cared for in less intensive, less expensive settings if they were readily available across the state. But it is also partly because Arkansas, like most of the rest of the country, has failed for decades to make significant changes in the *system* unless spurred to do so by some tragic set of circumstances involving violent acts by one or more persons suffering with lifelong psychiatric illness.

The Angela R. Settlement Agreement mandated that *"DCFS shall develop and implement a statewide plan for improving foster children's access to mental health services, through*

consultation with the Division of Mental Health and private providers of mental health services. This plan shall emphasize early detection and treatment of foster children's mental health problems, and the use of home- and community-based services whenever possible to avoid restrictive residential and institutional placements."

System Coordination Issues

State agencies do not have an effective, systemic approach that is coordinated and collaborative in regard to the planning, development, funding and oversight of the mental health system supported through public dollars. The plight of children in Arkansas is that many preventable, treatable emotional and behavior problems are going unattended and getting worse because our *system* of care is inadequate in terms of the limited range, availability, and appropriateness of services; numbers of trained mental health personnel; and funding. Funding sources for mental health services continue to be deficient and are not "flexible". There are few methods of "blending" funding that would allow for development of "wraparound" or non-traditional services that could result in improved outcomes for children.

The Department of Human Services, Department of Education and Department of Health should develop a more collaborative approach to program and budget planning in order to prevent duplication of services and fragmentation of the system of care. Changes in public policy that impact the children's mental health system should be made with the input of consumers, advocates and other stakeholders. CASSP was established through ACT 964 of 1991 and 1517 of 2001 for this specific purpose.

It is **recommended** that State agencies promote a systemic approach to mental health services that:

- Utilizes and enhances current successful systems and treatment approaches
- Compliments and supports rather than duplicates other relevant initiatives in state government, examples include:
    1. Child and Adolescent Service System Program (CASSP) legislation, as amended, and subsequent ongoing efforts to renew, revise, and expand the CASSP program
    2. Division of Medical Services' ongoing efforts to improve Medicaid services to Arkansas' children and youth (such as School-based Mental Health Services)
    3. Division of Youth Services initiatives to expand mental health services to committed youth in both institutional and aftercare settings
- Utilize the CASSP philosophy and services system- renewed legislation from the last session (ACT 1517 of 2001) provides for an enhanced and expanded development and implementation of CASSP
- Utilizes national "Best Practice" methodologies
- Address the needs of special populations
- Address multi-cultural competencies

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Legislative Issues

The executive and legislative branches of state government must come to an agreement regarding the type and quality of services that the children and families of Arkansas are entitled to and the level of funding that the state can afford. The two branches of government must then prioritize and actualize this level of services without delay remembering that Arkansas's children are our most precious resource.

All existing statutes and all policies and regulations promulgated by the Division of Mental Health Services governing the roles, responsibilities, and accountability of certified community mental health uniform, statewide baseline level of availability, accessibility, and quality of a prescribed array of publicly supported community-based mental health services for citizens of all ages, including those with mental illness and co-occurring substance abuse or developmental disorders.

The Governor's Office and the Director of the Department of Human Services should strongly encourage the Arkansas General Assembly, having sought advice from system stakeholders, to take the following actions

It is **recommended** that executive and legislative branches should:

- Evaluate Arkansas's public mental health system and hold those who manage it accountable for the effectiveness of the services they provide and for the public funds they control.
- Consider new approaches to financing and providing care for our mentally ill and emotionally disturbed children.
- Examine and revise as necessary the laws and public policies governing our public mental health system.
- Reassess the division of responsibility, chain of authority, and funding formula for the public mental health system.
- Include all those who have a stake in the system in our diligent search for better policy and more responsive and effective service system.
- Strengthen accountability for access, availability, and quality of care.
- Support effective community-based services.
- Push for reliance on evidence-based practices in mental health care.
- Create stable and adequate mechanisms for funding mental health services.
- Amend the Mental Health Parity Act of 1997 to require that all private health insurance plans marketed in Arkansas provide treatment for mental illness and substance abuse commensurate with that provided for major physical illnesses and offer access to all effective and medically necessary psychiatric medications.

- Fully fund Act 1589 of 2001 to provide for local indigent psychiatric inpatient care, and enact additional legislation necessary to support local, readily available alternatives to hospitalization—such as intensive case management like the Assertive Community Treatment (ACT) model, crisis stabilization services, and mobile crisis services—throughout the state. Additional funding mechanisms should be developed so that broad access to mental health services is retained without the addition of barriers such as co-pays or reductions in currently covered services.
- Update current commitment laws to expand commitment criteria while protecting the civil rights of Arkansans.
- Review and modify the single point of entry (SPOE) system for persons being considered for admission to the Arkansas State Hospital to reflect current circumstances and to reinforce the objective of assuring appropriate admissions to and discharges from the Arkansas State Hospital.

In shaping the major policies and making decisions that affect the state's public mental health system, the director of the Division of Mental Health Services must actively seek input from system stakeholders. These stakeholders should include but not be limited to the Arkansas Mental Health Planning and Advisory Council, the Arkansas Chapter of the National Alliance for the Mentally Ill and other appropriate consumer and advocacy organizations, the Department of Health, the Department of Education, directors of the community mental health centers, the Arkansas Hospital Association, the Child and Adolescent Services System Program (CASSP) Coordinating Council, and the Department of Human Services' Divisions of Children and Family Services, Youth Services, Developmental Disabilities Services, and Medical Services.

Access Issues

The array and intensity of services that are available on a timely basis varies greatly throughout the state. Even basic services, such as outpatient individual and family therapy, are minimal in some areas. Transportation continues to be a major barrier to receiving necessary services for many children and their families.

Insufficient access to appropriate levels of services results in increased utilization of higher levels of care that is more expensive to the system. A higher percentage of public funds are spent keeping children in residential and acute hospital care than the amount spent providing community-based care. This results in the majority of the dollars being spent on a very small percentage of the overall number of children that receive mental health services. Assure equitable access to admission to the Arkansas State Hospital's acute-care beds for children from all areas of the state.

It is **recommended** that DHS assure any future changes to the management of access to Medicaid-paid services are sensitive to assuring quick, appropriate access to services and to establish and support community based systems of care. DHS should consider automatically pre-authorized acute mental health services to support a range of community providers in assessing children and providing initial services without system delays. Need or intensity thresholds could be set to trigger prior authorization and utilization review practices for children needing higher amounts, greater lengths, and/or higher intensities of services. The less intensive, community based services that drive successful system of care functioning should be allowed to expand as fully as there are providers to deliver the services, supporting consumer choice where multiple providers are available, while management efforts focus on assuring that the most intensive (expensive) services are used as effectively as possible.

Service Delivery Issues

There should be a minimum level of service capacity in all regions for basic community based services in order to limit the utilization of more expensive, intensive services to children for whom those intensive services are the best and necessary choice. Availability and need for each of these services should be assessed and plans made to develop services needed but not available. An array of services should be the goal in each of the 15 mental health catchment areas, to include, but not limited to:

Crisis Stabilization and Response Services	Assessment and Evaluation
Outpatient Treatment	Case Management
Home-Based Services	Independent Living Services
Day Treatment	Family Support Services
Emergency Services	Respite Care
	Family Therapy

- Available and accessible more intensive residential services should be the goal in each of the 10 DCFS Service Areas or bordering area, to include, but not limited to:

  Therapeutic Foster Care
  Therapeutic Camp Services
  Therapeutic Group Care
  Residential Treatment Services
  Crisis Residential Services
  Inpatient Hospitalization

- The services identified above should address the needs of special populations, including but not limited to the following:

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1. Early Childhood-The CASSP Coordinating Council will lead the effort to expand services aimed at early identification and treatment for the needs among younger children before those needs escalate to the level of "severe" disturbances. This effort will require the building of collaborative partnerships with several types of expertise not necessarily included in partnerships discussed to this point, such as pre-school and day care providers, Head Start programs, pediatricians and family physicians, and other public health entities.

2. Older Youth- It is vital we address transition needs of adolescents with serious emotional disturbances as they age out of child-serving systems and potentially into adult service systems. The adult mental health system, in particular, does not offer enough programming specifically designed to address the needs of these young adults, leaving many of them unserved for several years following the age of majority. At the same time, public schools have the responsibility to serve these children until their 21st birthday, if they are subject to an Individualized Education Plan (IEP). All systems, child and adult, could work together to assure that the child and family are able to access needed services and supports from appropriate adult-serving systems before they exit child-serving systems.

3. Dually diagnosed youth- Services would be directed toward youth who have mental health issues and are either developmentally delayed or abuse substances. Agencies from the various disciplines must work closely together with the child and family to assess the need, plan and delivery of services.

4. Foster children who are transitioning back home- Often when a child in foster care is reunified with their parents, their eligibility for some services may be affected. DCFS, DMS, and DMH need to work together to assure seamless services so that treatment can be continued to provide the support necessary for successful reunification.

5. DYS committed juvenile offenders- DCFS needs to continue and enhance planning efforts with DYS, DMH, and DDS to serve adjudicated juveniles who are in need of mental health, substance abuse, developmental disability, or sex offender services.

The following programs need to develop and expand to address the needs of these special populations:

- Sex offender treatment programs: More residential and community-based outpatient programs are needed to meet current needs.

- Day Treatment programs: This level of intensive outpatient service can often prevent the need for out-of-home placement.

- Services provided in-home and at school: The Division of Mental Health Services developed an initiative with limited funding to Community Mental Health Centers for developing services provided in the school setting. This service appears to have positive outcomes for the children and schools. Further incentives could be established increase the number of programs that can provide these services in the child's natural setting.

- Respite services: Funding methods for this service category should be developed. This service has the potential for decreasing the public costs by decreasing utilization of higher levels of service such as residential and acute hospitalization.

- It is **recommended** that DHS assure all outpatient service definitions include the capability to provide those services in non-clinic environments, most notably in homes and in schools, and that payment/reimbursement structures include incentives for providers to deliver these services in community based and non-clinic-based locations. Consideration should be given to the development of a reimbursement model which offers differential rates for services delivered at defined distances from population centers, making it economically feasible for providers to commit staff to mobile service delivery, and that allows services to be offered at varying levels of intensity, according to each child and family's needs.

- It is **recommended** that case management be expanded and employed as a methodology to help families and the system manage services for those children and families with the most complex, severe, and/or complicated service needs. One approach would be for the state to consider the collaborative development of a "care management model" which would enable individual care managers to function as the system "point of accountability" for each individual child and family. Families whose children's needs are more complex or severe would have a single person assigned to serve as their primary contact, and that person should know about and help the family coordinate all efforts on behalf of that child and family, regardless of the system within which specific services may be provided. That person should help assure that adequate and appropriate assessments are obtained, as often as indicated, that treatment planning includes input from all needed persons or entities, that treatment plans are regularly reviewed and updated, and that interventions are provided in as coordinated and integrated a manner as possible.

- It is **recommended** that Act 1589 of 2001 be fully funded to provide for local indigent psychiatric inpatient care, and enact additional legislation necessary to support local, readily available alternatives to hospitalization—such as intensive case management like the Assertive Community Treatment (ACT) model, crisis stabilization services, and mobile crisis services—throughout the state. Additional funding mechanisms should be developed so that broad access to mental health

services is retained without the addition of barriers such as co-pays or reductions in currently covered services.

All possible avenues to secure Medicaid funding for medically indigent mentally ill patients who are hospitalized in community hospitals and local psychiatric hospitals should be pursued fully.

Resource Issues

Act 1517 of 2001 affirms that CASSP is to function as the "*structure for coordinated policy development, comprehensive planning, collaborative budgeting, and resource allocation for services to children with emotional disturbances"*. The Foster Child Mental Health Collaborative recognizes the challenges that face CASSP and the vital partnerships that will be required to eliminate the current barriers to full actualization of the functions described above. Perhaps the most significant concern of this planning group has been the knowledge that the many systemic changes and service improvements cannot be accomplished by CASSP (even with complete collaboration and cooperation from other child serving divisions within DHS) without additional funding, staff, and programming. Many of the needed resources might come from implementation of the recommendations that follow, however, these recommendations are offered with the full understanding that CASSP, as currently organized and funded, is not in a position to implement the following recommendations:

- Funding needs to be available statewide for the array of services as identified and should be flexible. "Decisions for expenditure of flexible funds shall be made at the regional or local level and must be approved by all involved service providers".

- DHS and the CASSP Coordinating Council should lead the construction of a cross-system state children's budget that identifies all resources and the services they purchase. Administrators in each system must move away from isolated decision-making practices because the impact of those resource decisions at the individual child/family level and at the community level is confusion and competition for limited resources

- DHS should examine the cost benefit of changing the State Medicaid plan to allow for universal access to services so that an entire range of services would be available to clients and their families. This analysis should include the opportunity for consumers, providers, and advocates to participate in well- structured public policy discussions statewide.

- Potential modifications to Arkansas's Medicaid State Plan, including various waivers, must be aggressively pursued to assure the availability of Medicaid reimbursement for newer, more effective, and more efficient evidence-based mental health services.

Potential modifications to Arkansas's Medicaid State Plan, including various waivers, must be aggressively pursued to assure the availability of Medicaid reimbursement for newer, more effective, and more efficient evidence-based mental health services.

- The Medicaid State Plan and the Medicaid Rehabilitation Services for Persons with Mental Illness (RSPMI) program should be updated to provide for reimbursement for recently developed services, including wrap-around case management such as Assertive Community Treatment (ACT), mobile crisis teams, family-oriented interventions, and a broader range of family and children's mental health services.

- The Arkansas Medicaid Program should be expanded to cover substance abuse treatment services to assure the integrated care and treatment of persons with co-occurring mental and addictive disorders.

- Any Medicaid requirement of prior authorization for outpatient mental health services should focus on the most intensive and expensive services, or on those people whose utilization of services significantly exceeds the norm, rather than on routine short-term or maintenance services.

- Any proposed change to the Arkansas Medicaid State Plan that will limit, restrict, or eliminate access to existing mental health benefits must contain an impact statement indicating any cost shifting that will result from the change. The impact statement shall include but not be limited to identifying: (1) other systems serving children and adults who will be affected by the change; (2) the dollar amount that will be shifted to those other systems; (4) the number of children, adolescents, and adults the change will affect; and (5) the outcomes expected from the change.

- The Division of Medical Services should require all early periodic screening, diagnosis, and treatment (EPSDT) screenings to include a screening instrument, jointly approved by the Division Medical Services and the Division of Mental Health Services, designed to identify mental health and addiction issues in the under-21 population. The instrument should be one that can be quickly and efficiently administered by personnel appropriately trained to use mental health and substance abuse treatment resources.

- DHS should explore the possibility of a private grant to fund comprehensive analysis and reorganization of the current funding situation. This would allow for a non-categorical, blended approach that would maximize utilization of federal dollars.

- Currently a disconnect often exists between responsibility to access services for children and authority to approve funding. This issue needs to be addressed in several ways:

    1. A system needs to be developed that allows for procurement of timely services.

2. The development and adequate funding of a non-categorical or integrated "care management model" (as recommended in the Services section) within the State of Arkansas for several reasons as follows:

   a) This model recognizes that no single system has adequate personnel to perform these functions alone in all parts of the state.

   b) It facilitates the building of shared information and processes between the systems, closing some of the information and service gaps identified.

   c) It recognizes that the complex or severe needs of children usually cross the boundaries between categorical service or need definitions, and successful interventions depend upon coordinated impact from many types of expertise. Under the current system such children and families are passed from one system to the next with inadequate continuity or coordination.

3. Flexible funding at the local level needs to be available to allow services to be wrapped around the child and family to prevent family disruption (wherever possible and appropriate) and to allow children to be served in the least restrictive environment. Prior to the development of a cross-system budget these funds need to be allocated to DCFS Areas to support service decisions made by CASSP teams.

Data Tracking Issues

Needs assessment has been hindered by limitations in the information available. Systems simply are not tracking information necessary to support effective management of available services. There are no uniform methodologies in place to track outcomes achieved in the lives of children and their families. Fundamental accountability systems must be established and utilized, oriented towards understanding and improving the outcomes of all services and supports purchased with public funds.

- There needs to be planning, implementation, management, and evaluation practices that clearly articulate system goals, the outcomes to be achieved in relation to those goals, and the service delivery practices necessary to achieve those goals.

- There needs to be collaborative oversight of plan implementation, planning and systems development, management information, monitoring and evaluation of services. Planning efforts that went into Benefit Arkansas should be considered in future planning activities.

- Management of public care for children with serious emotional disturbances and their families, including foster children, should be outcome based and must reflect ongoing collaborative interactions among all of the child-serving systems.

- It is strongly recommended that DHS work internally to link information management across all areas of responsibility and to move all information systems towards a standard platform to support those linkages. DHS is responsible for a number of different population groups and fund streams, most of which include specific, unique reporting requirements. At this time, DHS appears to be managing several separate, non-connected information systems, meeting requirements individually, but without the benefit of linkages between systems and the information they contain. Therefore, it is difficult to identify or report information about gaps or overlaps in the populations served and services provided, and it appears impossible to track potential cost shifting between programs or populations.

Training and Professional Development Issues

- Even if all funding issues were resolved, Arkansas does not have enough mental health professionals with expertise in children's mental health to meet the current need, especially in rural areas of the state. Human resource development must include plans to increase the number of mental health professionals with specific expertise in treating children, especially the early childhood, dually diagnosed and sex offender populations. This is a long-term issue that must be addressed by the system of care.

- It is **recommended** that interdisciplinary training be available and institutionalized to assure that staff from the various disciplines and agencies understand how the whole system works. This would include training for Family Service Workers in mental health services (e.g., knowledge of processes, procedures and resources, simple screening tools to determine the child's level of needed, how to partner with mental health providers in serving children and families.) It should also include specialized training for mental health professionals in issues about child maltreatment, foster care and adoption.

- It is **recommended** that DHS establish a time-limited Child Mental Health Expertise Professional Development work group to study shortages in expertise and make recommendations for the development of suitable training resources within Arkansas. Child mental health expertise needed in a community-based system of care is extremely limited in Arkansas. Therefore, state agencies must take the lead in determining how best to recruit, train, and retain appropriate expertise. The work group should include staff from DMS, DCFS, DYS, and DOE, as well as representatives from parent organizations, relevant professional organizations, and from tax-supported institutions of higher education that do or may offer relevant training programs. At the least, the work group should look at the fields of psychiatry, psychology, nursing, social work, special education, school guidance, and probation,

offering recommendations about how to develop and maintain statewide expertise in those and other relevant areas.

SUMMARY RECOMMENDATIONS

1. A comprehensive analysis should be done of all public dollars spent for children's mental health services. This analysis should be done with appropriate thresholds established that determine the levels and types of services that should be available and the numbers of children that should be utilizing those mental health services. These thresholds should be based on established statistics for Arkansas' population and the prevalence of mental health issues for this age group.

2. The Department of Human Services, Department of Education and Department of Health should develop a more collaborative approach to program and budget planning in order to prevent duplication of services and fragmentation of the system of care. Changes in public policy that impact the children's mental health system should be made with the input of consumers, advocates and other stakeholders. CASSP was established through ACT 964 of 1991 and 1517 of 2001 for this specific purpose.

3. Programs that increase community-based services should be supported and funded to decrease the need for more expensive, higher levels of care.

4. Methods of making funding more "flexible" should be explored so that "wraparound" services could be available to meet the needs children, who require more than what traditional services can offer.

5. Evaluation of clinical outcomes should be established for services purchased with public dollars to insure that evidenced-based "best practice" approaches are utilized in the system of care.

6. Cost containment for Medicaid and other public funds should be done through utilization management. Thresholds for utilization of services/dollars should be established with reviews of any individual or programs that fall outside those thresholds. The CASSP Coordinating Council supports utilization management processes that will increase positive clinical outcomes in addition to cost containment.

7. Any Medicaid prior authorization process implemented should utilize the definition of Medical Necessity that was established for the Benefit Arkansas program. (See Attachment B.) Benefit Arkansas was the Medicaid managed care program that was implemented in April of 2000 and terminated within three months. The design of Benefit Arkansas represented several years of work by state agencies, providers, consumers, family members and advocates. The design of the program included many aspects of an ideal system of care, including the definition of Medical Necessity.

8. Prior authorization processes should not require unnecessary paperwork on every child receiving services, which increases administrative costs for the state and services providers. Prior authorization should be reserved for those individuals and services that represent higher costs for the state.

9. A thorough evaluation of the current budget and any proposed changes should be done to determine if the results are "cost shifting" as opposed to "cost saving". The focus of any changes should be cost efficiency rather than only cost savings. In addition, the evaluation should include not only the dollars involved, but also the impact to the established systems of care and more importantly, the cost for children with mental health issues and their families.

10. Preventive services such as community parenting programs, mentoring programs, consultative services and training of various community organizations concerning mental health issues needs to be addressed especially funding and access.